Maternal and Child Health Bureau

Enhancing Partnerships between Title V, Medicaid, and Local Health Departments through EPSDT

September 10, 2003

Health Resources and Services Administration
Maternal and Child Health Bureau

Moderator: James A. Resnick, MHS

E.P.S.D.T.

Overview of the legislative history

Presentation by Kay Johnson
MCHB Web-based Teleconference
September 10, 2003

Since 1967, Medicaid has included a special child health benefit known as the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

The sweeping nature of the policy combined with some key problems in implementation tell us much about the nature of U.S. child health policy.

Why discuss EPSDT?

- EPSDT was designed to ensure comprehensive health coverage for Medicaid-eligible children, related to preventive, acute and chronic medical problems.

  Source: 42 U.S.C. Section 1396d(a)(4)(B); 42 U.S.C. Section 705(a)(1968).

- EPSDT has policy significance as the only U.S. entitlement to comprehensive child health services.

EPSDT GOALS

- Created in 1967 during Johnson Administration
  - "to discover, as early as possible, the ills that handicap our children" and
  - to provide "continuing follow up and treatment so that handicaps do not go neglected."
- Sweeping guarantee for comprehensive health coverage unlike any other in US health policy
  - To locate poor children, assess their health status, and ensure that they received the continuous and comprehensive medical care they needed. (Rosenbaum and Johnson, 1986)

What significant policy events?

- Created in 1967, with major amendments in 1972.
- Recodified in 1989, with a strengthened federal mandatory benefit definition.
- In 1993-94 health reform proposal, EPSDT benefits limited to children living in poverty.
- During 1995-1996, threatened by those "Medicaid Reform" through a block grant.
- In the 1996-97 policy debate that led to SCHIP, the EPSDT comprehensive benefit package was discussed and rejected.

EPSDT Legislation in 1967

- Amend Medicaid
  - To add coverage of preventive health care for children under age 21
  - Extend benefits, even if such services not covered for adults
- Amend Title V
  - To assure that state MCH agencies would seek out, screen, and treat children,
  - Medicaid to pay for services to eligible children

EPSDT Framework

Follow the letters:

Early - starting before problems worsen

Periodic - at regular intervals & as needed

Screening - comprehensive well child exams

with developmental, physical, and mental, plus separate vision, hearing, dental

Diagnosis - as appropriate

Treatment - all services (covered under federal law) needed for diagnosed conditions

EPSDT 1971 Federal Rules

- Initially states were required to pay for EPSDT screening (well-child) exams
- Under Federal rules promulgated in 1971
  - State Medicaid required to pay for immunizations, as well as vision, dental and hearing services
  - Plus, pay for any other medical care treatment needed to correct problems disclosed by EPSDT screening, so long as treatment otherwise covered under State Medicaid plan

EPSDT 1970s Implementation

- Clarifying rules promulgated in 1971
- Amendment in 1972
  - Shifted responsibility for outreach, identification, and screening from Title V to Medicaid agencies
  - Established financial penalty (repealed in 1981) for states failing to inform and furnish services

EPSDT Implementation Issues

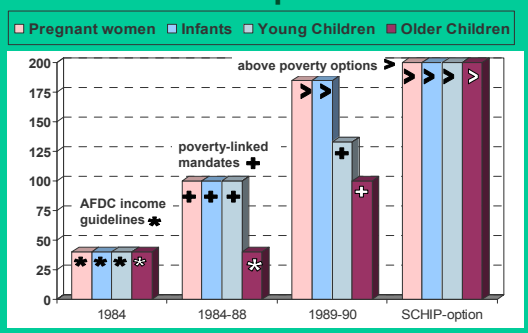
- Not all components of screening completed
- Billing well-child services outside EPSDT
- States covering less than full scope of benefits
- Inadequate provider protocols
- Medicaid is payer, often failed with outreach and similar obligations
- Many lawsuits aimed at enforcement of state roles and responsibilities

Sources: Rosenbaum and Johnson, 1986;Rosenbaum, 1983; Foltz, 1975; US GAO.

Medicaid and Children 1980-90

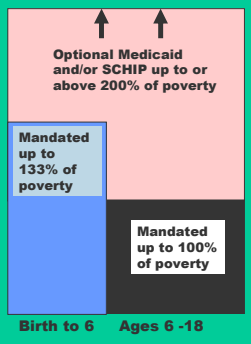
- 1981 REDUCTIONS in Reagan Administration
- 1984 DELINKING from AFDC begins
  - Mandatory coverage for children < age 5 born after **September 30, 1983**, with income below AFDC
- 1984-88 PHASE-IN of optional coverage
  - for infants, children ages 1-8, in foster care, etc.
- 1989 NEAR POOR children birth to age 6
- 1990 ALL POOR CHILDREN < 19
  - Mandatory coverage phased in until 2002

Incremental Expansions



Eligibility

- **Federal law mandates**:
  - Infants and children to age 6 up to 133% of poverty
  - Children ages 6-18 up to 100% of poverty
- **States options to cover others**
  - Medicaid at any level
  - SCHIP to 200% of poverty and above



EPSDT - OBRA 1989 Reforms

- Congress had expanded eligibility for children, now concerned about their benefits
- EPSDT was recodified in 1989 to strengthen federal mandatory benefits (1905(r)(5)
  - Mandated full range of Medicaid benefits permitted under federal law (1905(a))
  - Ended arbitrary limits on benefits, provider type, screen type (e.g. regular vs. interperiodic)
  - Allowed for provision of specific (unbundled) services, as medically necessary

EPSDT "Medical Necessity"

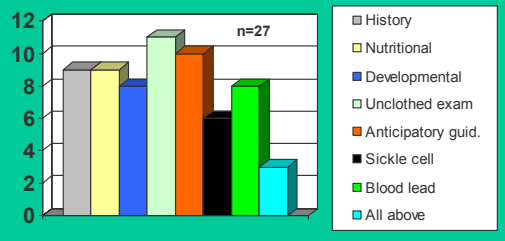
"Medically necessary" services covered

- EPSDT definition broader than most private plans
- EPSDT includes prevention & early intervention
- Thus, a service is medically necessary:
  - if service will prevention condition
  - if service will improve health or ameliorate condition
  - if service will cure or restore health

EPSDT - Challenges in 1990s

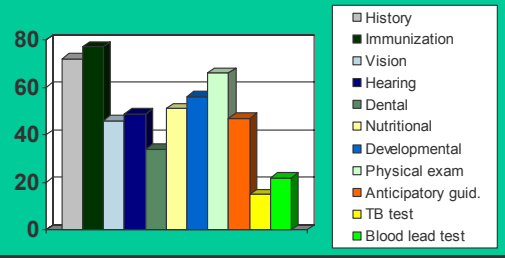
- In 1993-94 under Clinton health plan
  - EPSDT limited to children below poverty
  - Millions of children with disabilities and in near poor families would have lost benefits
- Medicaid block grant proposals of 1995
  - EPSDT benefit guarantees to be eliminated
  - States would have option to redesign benefits
- SCHIP enactment in 1996 - rejected EPSDT
  - States given option to design benefits
- Medicaid managed care explosion

EPSDT Managed Care Contracts Study



Percent of Medicaid managed care contracts with EPSDT screening components (27 states). Source: Rivera, Regan & Rosenbaum. CDF, 1995

EPSDT Quality Study - MI Advocates



Percentage of Michigan children (ages 0-6 years) enrolled in Medicaid managed care plans that received EPSDT screening, by service component. Source: Michigan Council on Maternal and Child Health, 2000

EPSDT and Title V Interaction

Required to develop interagency coordination agreements to address mutual objectives and responsibilities.

- EPSDT was created in to complement Title V
- Medicaid may delegate outreach, informing, transportation, and case management
- Joint management option
- Title V agencies can use EPSDT funding
- Title V calls for monitoring Medicaid
- Assist in contracts & administrative practices
- CSHCN wraparound

Sources: Rosenbaum and Johnson, 1984; Saunders, 1984; Van Dyck and Johnson, 1993

The Dual Nature of EPSDT

"The EPSDT program consists of two mutually supportive, operational components:

- assuring the availability and accessibility of required health care resources
- helping Medicaid recipient and their parents or guardians effectively use these resources."

- Fulfilling each continues to be challenging.

Sources: Center for Medicare and Medicaid Services, State Manual Part 5 EPSDT.

EPSDT Service Requirements

HRSA Web-based Training
September 10, 2003

EPSDT

- Early and Periodic Screening, Diagnostic and Treatment Services
- EPSDT is a preventive and comprehensive health program for Medicaid-eligible individuals under the age of 21.

EPSDT

- EPSDT provides children with access to comprehensive, periodic evaluations of health, development, and nutritional status, as well as, vision, hearing and dental services.

EPSDT

EPSDT is a mandatory service for most Medicaid eligible individuals

Early and Periodic Screening

- As part of the preventive aspect of the service, periodic examinations or screenings assure that health problems are diagnosed and treated early, before they become more complex and treatment more costly.
- Periodicity schedules for screening, dental, vision, and hearing services must be provided at intervals that meet reasonable standards of medical and dental practice.

Required Screening Services

- Screening : (as defined in statute)
  - comprehensive health and developmental history
  - comprehensive unclothed physical exam
  - appropriate immunizations (Advisory Committee on Immunization Practices (ACIP) schedule)

Required Screening Services

- laboratory tests (including blood lead assessment)

  Lead Toxicity Screening – All children are considered at risk and must be screened for lead poisoning at 12 and 24 months of age using a blood lead test. (Also, any child up to 72 months of age if they have never received a lead screen.)
- health education (including anticipatory guidance)
- Vision (including eyeglasses)
- Hearing (including hearing aids)

Required Screening Services

- Dental Services must include at a minimum:
  - relief of pain and infection
  - restoration of teeth
  - maintenance of dental health

Dental Services may not be limited to emergency services for EPSDT recipients.

Diagnosis

- When a screening examination indicates the need for further evaluation, diagnostic services must be provided.
- The referral should be made without delay.
- Provide follow-up to make sure that the child receives a complete diagnostic evaluation.

Treatment

- Health care must be made available for treatment or other measures to correct or improve illnesses or conditions discovered by the screening service. All Medicaid coverable, medically necessary, services must be provided even if the service is not available under the state plan to other Medicaid eligibles. *The state Medicaid agency determines medical necessity.*

Required State Activities

- Inform all Medicaid-eligible children under 21 and their families or guardians that EPSDT services are available.
- Set distinct periodicity schedules for screening, dental, vision and hearing services.
- Report EPSDT performance annually to CMS using the form CMS-416.

Required State Activities

- Inform all Medicaid-eligible children that transportation and appointment scheduling assistance are available on request.

Required CMS Activities

- Provide states with technical assistance, data, and evaluation results to facilitate EPSDT program implementation.
- Collect and analyze CMS-416 data

Issues for Discussion

- If health plans and providers are not clearly informed of the broad package of benefits offered under EPSDT and their responsibilities to provide covered services, it can cause confusion and potential under-service.

Issue for Discussion

- EPSDT Litigation Activities – Many states are involved in lawsuits regarding the provision of EPSDT services. There are several consistent issues:
- 80% participation goal
- Informing
- Access to services (dental and mental)

Putting the T into Action

Phyllis Sloyer, RN, PhD
Division Director
Florida Department of Health

Title V Partnership Possibilities

- Identify Specialty Services for Medicaid Agencies
  - Title V relationships with Centers of Excellence
    - Craniofacial
    - Spina Bifida
    - Cardiac

Title V Partnership Possibilities

- Use Early Identification & Intervention Systems
  - Title V Role in Follow-up for Newborn Screening
  - Title V Role in Early Intervention Programs

Getting to the "T"

- Title V Role in Care Coordination
  - Provide support services to access treatment (e.g., faciliate transportation services)
  - Support care coordination in the medical home
  - Promote parent collaboration and involvement in the system

Medical Necessity Role

- Title V consultant review
  - Offer consultant expertise
  - Offer unique team arrangements to review medical necessity and make recommendations to Medicaid
- Title V role in utilization review
  - Partner with Medicaid to review utilization patterns and make recommendations

Conclusions

- What are your strengths?
- What can you bring to the table?
- Do you have someone who can advocate for you with the Medicaid program?

EPSDT Annual Reporting

Using the CMS-416

CMS-416

- Reporting Requirements
  - **The number of children provided child health screening services;**
  - **The number of children referred for corrective treatment;**
  - **The number of children receiving dental services; and**
  - **The state's results in attaining the participation goals set for the sate under section 1905(r)**

CMS-416

- Other data required by CMS-416 includes:
  - State periodicity schedule
  - Average period of eligibility
  - Total number of eligibles in managed care
  - Total number of screening blood lead tests

CMS-416

- Data collected is used to determine participation ratio and screening ratio
  - **Participation ratio is the number of children receiving at least one screen in a year.**
  - **Screening ratio indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by the state's periodicity schedule (adjusted by the proportion of the year they are Medicaid eligible.**

CMS-416

- Participation Goal
  - Set by CMS (HCFA) on behalf of the Secretary in 1990.
  - CMS set incremental goals.
  - States were to achieve 80% participation rate by 1995.
  - Goal has not changed though some states have not achieved 80%

CMS-416

- CMS has no authority to sanction states not attaining 80% goal
- We continue to work with states to improve accurate and consistent reporting

CMS-416

- ISSUES
  - Reporting managed care data
  - Litigation regarding states' achievement of 80% goal

Changing Roles of State Medicaid and Public Health Agencies

Rosemary E. Murphey, RN, MBA

Maryland Department of Health
and Mental Hygiene
September 10, 2003

Background on Maryland

- HealthChoice is Maryland's statewide mandatory Medicaid managed care program
- >450,000 people in HealthChoice (80% of Medicaid enrollees)
- 75% of HealthChoice enrollees are children
- HealthChoice was the platform for major program expansion with 1998 implementation of MCHP
- 60% of children on Medicaid gained eligibility as a result of expansions (total of 403,076 children on Medicaid)

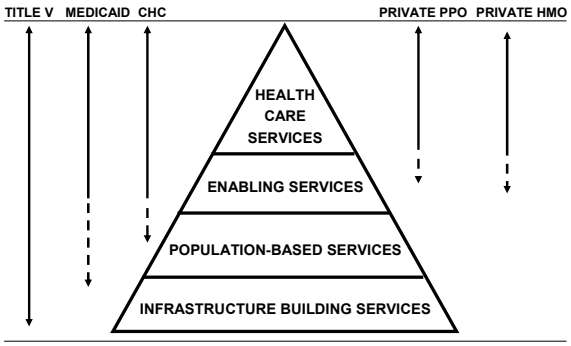
Medicaid Trends

- Growth in managed care
- Growth in size of Title V population
- Growth in payment for expanded services
  - Expanded EPSDT (e.g., Therapeutic Behavioral Services)
  - HCBS Waiver programs
  - More Medicaid reimbursement of traditional Title V "wraparound" services

Title V Trends

- Focus shifting down the pyramid, away from provision of health care services
- Medicaid reimbursement policies support changing focus

Health Services Pyramid



Medicaid Managed Care Supports Pyramid Shift

- Patient focused system with medical home
- Comprehensive, prevention oriented system
- Incentives to pay for enabling, population-based, and infrastructure services to reduce costs of health care services

Partnership is Essential

- Impossible to meet all the needs of the general and Medicaid populations without each other
  - Medicaid financing of Title V services increasingly important as the Medicaid population expands
- Title V status for some providers gives Medicaid more flexibility to pay higher cost-based rates
- LHDs bring sensitivity to regional issues and direct client experience

Partnership Activities

- Reimbursement of services
- Coordination and linkages related to beneficiary outreach and eligibility
- Provider networks and delivery systems
- Quality assurance
- Infrastructure and data exchange

Medicaid Reimbursement for Health Care Services

- Direct Medicaid reimbursement for specific services
- Costs built into HealthChoice MCO rates
- FQHC and LHD safety net providers reimbursed at higher cost-based rates
- Medicaid is the most comprehensive payer of mental health services

Medicaid Reimbursement of Enabling Services

- Examples of Maryland Medicaid's reimbursement of Title V enabling services
  - Transportation (via grants to LHDs)
  - Translation
  - Healthy Start targeted case management
  - Enhanced rate for prenatal health education
  - Substance abuse counseling for pregnant women
- Coverage of more enabling services (e.g., respite) under HCBS Waivers

Medicaid Reimbursement of Population-based Services

- Examples of Maryland Medicaid's reimbursement for Title V population-based services
  - Newborn screening
  - Lead screening
  - Immunizations/Vaccines for Children program
  - Oral health

Medicaid Infrastructure Building Activities

- Examples of Maryland Medicaid's infrastructure building activities
  - HealthChoice MCOs participate in Fetal and Infant Mortality Review Teams, lead screening and other initiatives

Outreach and Eligibility

- LHDs conduct HealthChoice eligibility and enrollment for MCHP
- LHD ACCUs
- LHD Ombudsmen
- LHDs' ongoing contact with enrollees provides anecdotal feedback on programs
  - Informs communications to enrollees

Provider Networks and Delivery Systems

- In FY 2003 Medicaid increased physician fees for E & M services by $50 M (TF)
- HealthChoice's stronger provider networks have improved access
- Title V provides links among health plans/providers and other community based agencies and resources

Quality Assurance

- Title V and Medicaid share performance measures
  - Immunizations
  - Medicaid service utilization
  - Prenatal care
  - Lead screening
  - Family Planning Waiver service utilization
  - Asthma
- Medicaid taps into Title V expertise to develop policies and standards of care for health plans
  - Healthy Kids (EPSDT)
  - CSHCN (HIV/AIDS, Speech therapy)
  - Lead case management

Data Exchange and Infrastructure

- Title V provides population-level data for planning and benchmarking
- Medicaid provides encounter data that can be extrapolated to general population
- Population-level databases promote public health as well as QI for health plans
  - Prenatal Risk Assessment Database used by Medicaid
  - Medicaid analyzes encounter data and lead registry data to inform health plans of children in need of follow-up for elevated levels

Partnership is Evolving

- Early Phase: Medicaid expansion
  - LHD played key role in conducting eligibility and enrollment
  - Expanded the Title V population eligible for Medicaid reimbursement
  - Reimburse schools and the Infants and Toddlers Program for therapies
- Recent Phase: Quality assurance
  - Collaboration on standards
  - Success in improving access to preventive care
  - Stabilization of provider networks
- Reimbursement evolving to meet changing needs (e.g., LHD administrative claiming)

Emerging Phase

- Collaborate to address gaps in care
- Collaborate to address more complex needs

Address Gaps in Care

- Oral health
  - Work with LHDs to mobilize community to address provider shortages
- Breast and cervical cancer
  - Expand Medicaid to women in need of cancer treatment who were screened through WBCCP

Address Complex Needs

- Need Title V expertise
- Collaborate to establish a strategic approach to case management
  - Medicaid is paying for multiple types of case management
  - Need to manage the case managers
- Collaborate to meet needs of special populations
- Reimburse schools and the Infants and Toddlers Program for therapies

Conclusion

- Partnership is essential and must be flexible to meet changing needs
- Managed care principles and reimbursement policies support evolution

Making the Case: Why State Medicaid and Title V Agencies Should Forge Partnerships?

Wednesday, September 10, 2003

Peggy Bailey, Health Care Financing Policy Analyst
Association of Maternal and Child Health Programs

It's about the kids!

- **Title V and Medicaid are very different programs with one uniting feature**
- **Together, Title V and Medicaid provide quality, consistent services.**
- **Therefore, a partnership is not just a nice idea, its essential.**

Federal Statute Requirements

- **Title V statute requires state agencies to participate in coordinating EPSDT services**
- **Title V is charged with identifying Medicaid eligibles**
- **Medicaid and Title V partnerships require formal agreements**
- **Title V is the payer of last resort for Medicaid and SCHIP**

Overcoming Language Barriers

- **Medicaid success is often determined by ability to control costs**
- **MCH success is determined by number of people reached**

This may not sound like a problem, but it can be if differences aren't acknowledged.

Medicaid's challenges

- **Program has grown beyond its original intent**
- **Program has stringent requirements**
- **2/3 of cost goes to 1/3 of the participants**
- **Politically impossible to cut services to seniors**

What MCH brings to the table?

- **A flexible funding source**
- **Title V can find the kids**
- **Strong history of performance measures**
- **Expertise in delivery of child development services**
- **Title V funds can be used for wrap around services**

Title V's Challenges

- **The MCH Block Grant is a relatively small funding stream**
- **Broad mission – difficult to explain outside the public health community**
- **Lacks public recognition – services are sometimes invisible to the general public**

What Medicaid brings to the table

- **Money – direct reimbursement to providers**
- **EPSDT is mandatory**
- **Public recognition**
- **Strong political leverage**

Why should we partner?

- **Medicaid and Title V have a responsibility to serve children**
- **Both need help overcoming challenges**
- **The foundation for collaboration has been set**
- **None of this is easy but in order to meet the goal, collaboration must happen**

Washington State
Forging the Bond: State and Community Partnerships

Margaret Wilson
Department of Social and Health Services
Medical Assistance Administration
September 10, 2003

Background

- DSHS MAA is the state Medicaid agency
- Collaborates with Title V agency, DOH
- Charged with getting EPSDT services to Medicaid children in our state
- We have a long history of partnering with other groups in our state to accomplish this goal

Goal of Collaboration

- MAA works closely with our partner, Department of Health, to improve access and quality of EPSDT services to children and adolescents

Strategies to Accomplish Goal

1. Develop a "community approach" to child health & development services.
2. Unify and improve health & developmental information and education to families.
3. Collaborate with partners in identifying, and implementing strategies for improved delivery of ESPDT services.

Medical Assistance Administration's Partners include

- Department of Health
- University of Washington
- Local Health Departments
- Children's Administration
- Managed Care Plans
- Washington Chapter of AAP
- Local Schools

Medical Assistance Administration and Partner activities include

- Development of a set of Well Child Exam charting forms for providers to use when charting the results of EPSDT exam
- Participate with Department of Health's CHILD Profile program
- Chair the EPSDT Improvement Team

Well Child exam forms

- These are age specific
- They include a copy for parents to keep
- The reverse side of parent's copy includes anticipatory guidance and resource information in several languages
- To view forms, go to www.wa.gov/dshs/dshsforms/forms/eforms/html

EPSDT Improvement Team

- The goal of the team is to work collaboratively on EPSDT problems and issues that come up
- Meets quarterly
- Has a broad representation of stakeholders

Washington State
Forging the Bond: State and Community partnerships

Lorrie Grevstad RN MN
Child and Adolescent Health
Maternal Child Health
WA State Department of Health
September 10, 2003

Keys to Successful MCH & EPSDT Programs

- Partnerships at a state & local level …
- Build on existing programs and opportunities…
- Think about where children and adolescents are now …

Partnerships …

- Washington Chapter, American Academy of Pediatrics
- Local Public Health Jurisdictions
- Schools
- Head Start, State Preschool Program
- Teen Health Centers
- Managed Care

Build on Existing Programs

- Healthy Child Care Washington
- Local Child Care Health Consultation
- Bright Futures
- CHILD Profile
- Adolescent health
- WIC

Reaching children & adolescents where they are …

- Schools
- Teen Health Centers
- Child Care
- Head Start, Early Head Start, preschool
- WIC Programs
- Parents, grandparents, caregivers

Lessons Learned

- Takes time but worth it
- Think beyond the usual 'players'
- Existing MAA-MCH collaboration helps position for grant opportunities
- Population-based approach as well as direct service approaches

Washington State
Forging the Bond: State and Community Partnerships

Kids Get Care
Lisa Podell, Program Manager
King County Health Action Plan
Public Health - Seattle & King County

September 10, 2003

Mission

The mission of the King County Health Action Plan is to implement innovative collaborative policy development and pilot projects that focus on system change and improvement of worsening health trends affecting vulnerable populations within King County.

Kids Get Care (KGC) is a program to ensure that children, regardless of insurance status, receive early integrated preventive physical, oral, developmental and mental health services through attachment to a health care home.

Children's Health Needs

- Only 21% of children insured by Medicaid in Washington State had a complete Well Child Check (WCC) in 2001. [1]
- Children who seldom or never have the same doctor are 60% more likely to visit an emergency room and 54% more likely to be hospitalized. [2]
- Behavioral and emotional problems are 1.5 to 2 times more frequent in households with lower family incomes. [3]
- Over 50,000 Medicaid eligible children five years of age and younger live in King County [4]
- Less than a third of this Medicaid eligible population currently utilizes dental services [5]
- Less than 5% of infants and toddlers (one year or less) have seen a dentist [6]

Kids Get Care Community Collaborators

- King County Health Action Plan
- Public Health - Seattle & King County
- Washington Health Foundation
- Washington Dental Service Foundation
- Community Health Centers of King County
- Puget Sound Neighborhood Health Centers
- Odessa Brown Children's Clinic
- Puget Sound Educational Service District
- Seattle Public Schools Head Start Program
- Bright Futures
- University of Washington
- Harborview Medical Center

Train the Trainer

- WHO: staff at CBOs; Head Start, ECEAP, WIC, Homeless shelters, etc
- WHAT: "Developmental Red Flags", Health Care Homes, Prevention
- RESULTS: 2300 Health professionals and CBO staff trained 25,000 kids screened for developmental delays in first 18 months

Operationalizing Integration in the Clinic

Case managers assure services are completed

"Seize the moment"

•Oral screening/education/ fluoride varnishes by PCPs

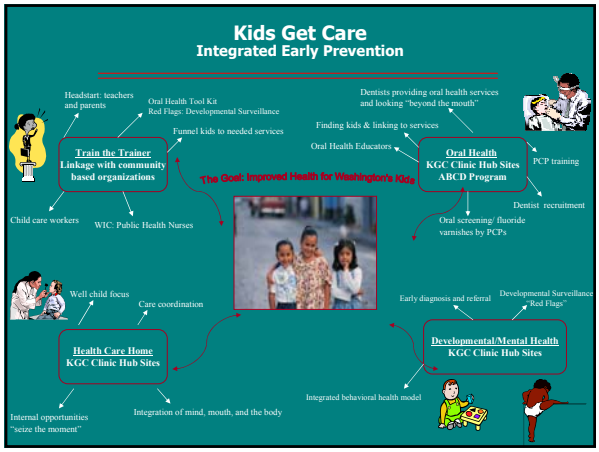
•PCPs refer kids to dentists, prioritizing high risk

•Dentists provide oral health services and look "beyond the mouth"

•Dentists refer kids needing medical home to medical clinic

•Train Primary Care Providers (PCPs) in oral screening/education/ fluoride varnishes

Kids Get Care - King County Health Action Plan



18 Month Program Achievements

- Established medical homes for **5,000** children
- Increased Well Child Checks by **55%**
- Increased numbers of 2 years old up to date Well Child check by **38%--when two year olds are up to date on Well Child Checks they are 48% less likely to have avoidable hospitalizations. 1**
- Trained **2,300** health professional and CBO staff to provide oral and developmental health screenings and health care home linkages
- Screened/scanned **25,000** children for developmental delays and oral health
- Produced Red Flags developmental surveillance tool

18 Month Oral Health Program Achievements

- Trained **270** outreach workers in oral health promotion/education
- Trained **150** medical providers in preventive oral health practices
- Increased oral health screenings by medical providers by **66%** at High Point Medical Clinic
- Increased toddlers seen at dental clinic by **49%** as result of screening and risk assessment in medical clinic at Odessa Brown Children's Clinic
- Increased birth to 5 year olds seen in both medical and dental clinics at High Point Medical/Joe Whiting Dental by **28%**
- Developed 2 oral health risk assessment tools for providers and lay people

Kids Get Care Tools

- Developmental surveillance "Red Flags" Checklist for community
- Oral Health "Red Flags" checklist for community
- Clinical Caries risk assessment training tool for clinicians
- www.metrokc.gov/health/kgc/

Recipe for Success

- **People**
  - Case managers
  - Trainer
  - Community advocates
- **Resources**:
  - Age specific EPSDT forms
  - Risk assessment tools
  - Health Ed materials
- **Infrastructure**
  - FQHCs or community based clinics
  - CBOs
  - Central referral source (CHAP, HMHB)

Kids Get Care System Change Elements

- Replicable and flexible
- Build on unique community assets and needs
- Emphasize "Services First"
- Seize moments of opportunity for integration
- Embed activities internally to sustain change
- Invest in integrated early prevention to produce cost savings

"I always skate to where the puck is going, not to where it's been."

- Wayne Gretzky

References

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4 - 6 Medical Assistance Administration 2002-2003

Maternal and Child Health Bureau

Questions and Answers